

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032841

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 385

Primary Registration District No. 3038

Registrar's No. 453

FILED AUG 28 1963

1. PLACE OF DEATH a. COUNTY LINN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY LINN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN BROOKFIELD		c. CITY OR TOWN BROOKFIELD	
Length of stay in 1b 39 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 216 E. HELM		d. STREET ADDRESS (If outside, give location) 216 E. HELM	
3. NAME OF DECEASED (Type or print) First ERMA Middle DELLA Last SELLERS		4. DATE OF DEATH Month AUG. Day 18 Year 1963	
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-30-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11a. FATHER'S NAME PETER GATES		11b. MOTHER'S MAIDEN NAME EMMALINE PRICE	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		12b. SOCIAL SECURITY NO. 1760	
13a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke		13b. INTERVAL BETWEEN ONSET AND DEATH 1 week	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) diabetic mellitus	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 1960 to 1963 and last saw him alive on 7-18-63		Death occurred at 2:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE W. J. O'Connell		22b. ADDRESS Brookfield Mo	
22c. DATE SIGNED 8-18-63		22d. LOCATION (City, town, or county) BROOKFIELD, MO.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 8-21-1963	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town, or county) BROOKFIELD, MO.	
24. FUNERAL DIRECTOR WRIGHT FUNERAL HOME, BROOKFIELD, MO.		25. DATE RECD. BY LOCAL REG. 8-20-63	
26. REGISTRAR'S SIGNATURE Anna Walker			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF

AUG 29 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.